DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03-14 | 2. STATE: Florida

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 702 of BIPA

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ -0-
b. FFY 2004 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 2 to Attachment 4.19-B, Version IV

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 2 to Attachment 4.19-B, Version III

10. SUBJECT OF AMENDMENT:
Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) - Revision of Scope of Service

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Will be sent when received

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bob Sharpe

13. TYPED NAME:
Bob Sharpe

14. TITLE:
Deputy Secretary

15. DATE SUBMITTED: 6/23/03

16. RETURN TO:
Mr. Bob Sharpe
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

ATTN: Kay Newman

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
June 24, 2003

18. DATE APPROVED:
December 29, 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Hugh Webster

21. TYPED NAME:
Hugh Webster

22. TITLE:
Acting Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS: Approved with the following changes per attached revised 179 that was submitted on 10/15/03: Item 7 changed from "FFY 2003 = $0" to "FFY 2003 = $137,002" and "FFY 2004 = $0" to "FFY 2004 = $271,150"

FORM HCFA-179 (07-92)

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FLORIDA TITLE XIX FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC REIMBURSEMENT PLAN VERSION IV

EFFECTIVE DATE: APR 01 2003

I. Cost Finding and Cost Reporting

A. Each Federally Qualified Health Center (FQHC) entering the Florida Medicaid FQHC Program on or after January 1, 2001 , in accordance with section V.C.(2), shall submit a cost report postmarked or accepted by a common carrier no later than 3 calendar months after the close of its cost reporting year. A complete, legible copy of the cost report shall be submitted to AHCA.

B. Cost reports available to AHCA pursuant to Section IV, shall be used to initiate this plan.

C. Each FQHC submitting a cost report in accordance with Section I(A) above is required to detail costs for its entire reporting year, making appropriate adjustments as required by this plan for determination of allowable costs. A prospective reimbursement rate shall not be established for an FQHC based on a cost report for a period less than 12 months or greater than 18 months. For a new provider with no cost history, excluding new providers resulting from a change in ownership where the previous provider participated in the program, the budgeted rate shall be the lesser of: .

   a. The reimbursement ceiling, or

   b. The budgeted rate approved by AHCA based on Section III of the Plan.

Budgeted rates shall be cost settled for the interim rate period. Budgetedrates shall not be approved for new providers resulting from a change in ownership. Medicaid reimbursement is FQHC specific and not provider specific.

D. The cost report shall be prepared in accordance with the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 Code of Federal Regulations (CFR) 413 (2000, and further interpreted by the Provider Reimbursement Manual CMS-Pub. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C., except as modified by this plan.

E. For the required cost report, each FQHC shall file a legible and complete cost report within 3 months, or 4 months if a certified report is being filed, after the close of its reporting period. Medicare-granted exceptions to these time limits shall be accepted by AHCA. A FQHC which does not file a legible and complete cost report within 6 calendar months after the close of its reporting period shall have its provider agreement cancelled.

F. AHCA shall retain all uniform cost reports submitted for a period of at least 5 years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 45 CFR 205.60 (2000). Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes.

G. In accordance with section V.D.(1), each Rural Health Clinic (RHC) entering the Florida Medicaid RHC Program on or after January 1, 2001 shall submit a Rural Health Clinic Form 222-Medicare cost report postmarked or accepted by a common carrier no later than 3 calendar months after the close of its cost reporting year. A complete, legible copy of the cost report shall be submitted to AHCA.

II. Audits

All cost reports and related documents submitted by the providers shall be either field or desk audited at the discretion of AHCA.

A. Description of AHCA's Procedures for Audits - General.

1. Primary responsibility for the audit of providers shall be borne by AHCA. AHCA audit staff may enter into contracts with CPA firms to ensure that the requirements of 42 CFR 447.202 (2000) are met.

2. All audits shall be performed in accordance with generally accepted auditing standards as incorporated by reference in Rule 21A-20.008 (4-21-91) F.A.C. of the American Institute of Certified Public Accountants (AICPA).

3. The auditor shall issue an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all Federal and State regulations pertaining to the reimbursement program for FQHC's. All reports shall be retained by AHCA for 3 years.

B. Retention

All audit reports issued by AHCA shall be kept in accordance with 45 CFR 205.60 (2000).

C. Overpayments and Underpayments

I. Any overpayments or underpayments for those years or partial years as determined by desk or field audits, using approved State plans, shall be reimbursable to the provider or to AHCA as appropriate.

2. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.

3. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.

4. The terms of repayments shall be in accordance with Section 414.41, Florida Statutes.

5. All overpayments shall be reported by AHCA to HHS as required.

6. Information intentionally misrepresented by an FQHC or RHC in the cost report shall result in a suspension of the FQHC or RHC from the Florida Medicaid Program.

D. Appeals

For audits conducted by AHCA a concurrence letter that states the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with Section 59-1.021, Florida Administrative Code (F.A.C.), and Section 120.57, Florida Statutes, for any or all adjustments made by AHCA.

III. Allowable Costs

Allowable costs for purposes of computing the encounter rate shall be determined using Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413 (2000), and the guidelines in the Provider Reimbursement Manual CMS-Pub. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. except as modified by Title XIX of The Social Security Act (The Act), this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid Program. These include:

A. Costs incurred by an FQHC or RHC in meeting:

1. The definition of a federally qualified health center and rural health clinic as contained in Section 4161(a)(2) of the Omnibus Budget Reconciliation Act of 1990 as described in Section 1861(aa)(1)(A)-(C) of the Social Security Act.
2. The requirements established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR 431.610(c)(2000).
3. Any other requirements for licensing under the State law which are necessary for providing federally qualified health center services.

B. An FQHC shall report its total cost in the cost report. However, only allowable health care services costs and the appropriate indirect overhead cost, as determined in the cost report, shall be included in the encounter rate. Non-allowable services cost and the appropriate indirect overhead, as determined in the cost report, shall not be included in the encounter rate.

C. Medicaid reimbursements shall be limited to an amount, if any, by which the rate calculation for an allowable claim exceeds the amount of a third party recovery during the Medicaid benefit period. In addition, the reimbursement shall not exceed the amount according to 42 CFR 447.321 (2000).

D. Under this plan, an FQHC or RHC shall be required to accept Medicaid reimbursement as payment in full for covered services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from Medicaid recipients. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid bad debts generated by Medicaid recipients. Bad debts shall not be considered as an allowable expense.

E. Allowable costs of contracts for physician services shall be limited to the prior year's contract amount, or a similar prior year's contract amount, increased by the Medicare approved rate of increase for services rendered in the contract.

F. For RHC's, Medicaid will accept the annual audited cost report established by the Medicare carrier.

IV. Standards

A. For the new Medicaid Prospective payment System (PPS), January 1, 2001 through September 30, 2001, Medicaid will compute a base rate for current FQHC's and RHC's by taking the average of their Medicaid rates set by the centers fiscal year 1999 and 2000 cost reports. Beginning October 1, 2001, and every October 1 thereafter, the FQHC's and RHC's rate will be increased by the percentage increase in the Medicare Economic Index (MEI) for applicable primary and preventative care services for that Fiscal Year

B. Changes in individual FQHC and RHC rates shall be effective October 1, of each year.

C. For new providers entering the program on or after January 1, 2001, the initial rate shall be established by taking an average of the rates for centers in the same county or district, with similar caseloads.

D. In the absence of centers in the same county or district, with similar caseloads, cost reporting methods will be used. A facility encounter rate will be calculated and compared to a reimbursement ceiling. The reimbursement ceiling shall be established and applied to all new providers entering the Medicaid program on or after January 1, 2001. The reimbursement ceiling shall be calculated by taking the sum of all the prospective rates divided by the number of providers in the Medicaid program. The base rate shall be calculated as the lower of the encounter rate or the reimbursement ceiling.

E. For purposes of this plan, a change in scope of service for a FQHC and RHC is defined as:

(a) the addition of a new service not previously provided by the FQHC or RHC;

(b) the elimination of an existing service provided by the FQHC or RHC.

F. A change in the cost of a service such as an addition or reduction of staff members to or from an existing service is not considered a change in scope of service.

G. It is the responsibility of the FQHC and RHC to notify the Division of Medicaid of any change in scope of service and provide proper documentation.

H. The individual FQHC's and RHC's prospectively determined rate shall be adjusted only under the following circumstances:

1. An error was made by AHCA in the calculation of the rate.
2. A provider submits an amended cost report used to determine the rates in effect. An amended cost report may be submitted in the event that it would effect a change of 1 percent or more in the total reimbursement rate. The amended cost report must be filed within 12 months of the filing date of the original cost report. An audited cost report may not be amended. A cost report shall be deemed audited 30 days after the exit conference between field audit staff and the provider has been completed.
3. Further desk or on-site audits of cost reports used in the establishment of the prospective rates disclose a change in allowable costs in those reports.
4. An increase or decrease in the scope of service(s), which has been approved by The Bureau of Primary Health Care (BPHC) as appropriate. Only the incremental increase or decrease in the scope of services will be applied to the provider's rate. The effective date of the rate adjustment will begin the first day of the month following the AHCA approval date.

5. For FQHC's who experience an increase or decrease in their scope of service(s) and request an adjustment to their rate must meet the following criterias:

    a. The scope of service must be approved by BPHC. Decreases in scope of service(s) that do not require BPHC approval should be reported to AHCA.

    b. The AHCA approval date for scope of service increases will be the latter of the date the service was implemented or 75 days prior to the date the request was received. The AHCA approval date for scope of service decreases will be the date the service was terminated.

    The providers' Fiscal Year End (FYE) audit must be submitted before the scope of service increase can be approved.

    c. The financial data submitted for the scope of service increase or decrease must contain at least six months of actual cost information.

    d. If no financial data for the scope of service increase or decrease has been received within 12 months after the FQHC's FYE in which costs were first incurred, the scope of service request shall be denied.

6. For RHCs who experience an increase or decrease in their scope of service(s) of greater than 1 percent and request an adjustment to their rate must meet the following criteria:

    a. The AHCA approval date for scope of service increases will be the latter of the date the service was implemented or 75 days prior to the date the request was received. The AHCA

approval date for scope of service decreases will be the date the service was terminated.

b. A copy of the most recent audited Medicare cost report must be filed with the request.

c. Submit a budgeted cost report (RHC Form 222-Medicare), which contains the increase or decrease costs associated with the scope of services.

d. If no financial data for the scope of service increase or decrease has been received within 12 months after the RHC's FYE in which the costs were first incurred, the scope of service request shall be denied.

I. Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider in accordance with 59-1.021 F.A.C., and Section 120.57 Florida Statutes.

J. Allowable cost relates to services defined by Section 1861(aa) (1) (A)-(C) of the Social Security Act as:

- physician services;
- services and supplies incident to physician services (including drugs and biologicals that cannot be self administered);
- pneumococcal vaccine and its administration and influenza vaccine and its administration;
- physician assistant services;
- nurse practitioner services;
- clinical psychologist services;
- clinical social work services.

Also, included in allowable cost are cost associated with case management, transportation, on-site lab and